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UNIVERSITY OF ALBERTA

THE EFFECTS OF CHILDHOOD SEXUAL ABUSE ON THE DEVELOPMENT OF EMPATHIC RESPONSIVENESS

BY

APRILE FLICKINGER

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requriements for the degree of MASTER OF EDUCATION.

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

(FALL 1991)

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled THE EFFECTS OF CHILDHOOD SEXUAL ABUSE ON THE DEVELOPMENT OF EMPATHIC RESPONSIVENESS submitted by APRILE FLICKINGER in partial fulfilment of the requirements for the degree of MASTERS OF EDUCATION in COURSELLING PSYCHOLOGY.

Dr. L.L. Stewin (Supervisor)

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DATE: Oct. 4, 1991

Abstract

In this study, the relationship between being sexually abused as a child and the victim's empathic responsiveness as an adult was explored. Undergraduate and graduate volunteers were asked to complete two self-report questionnaires: the Interpersonal Reactivity Index (Davis, 1980), composed of four scales that measure different aspects of empathy, and the personal Experiences Questionnaire designed for this study to assess the nature of certain childhood experiences. Present research indicates that victims of childhood sexual abuse (CSA) often experience long-term negative effects from the abuse experience (Finkelhor, 1986). Based on the literature, it was hypothesized that CSA affects the development of empathy by inhibiting its progression to more mature forms of response. Therefore, it was predicted that CSA victims would score significantly lower on empathy scales that measure mature forms of empathic responsiveness than would non-victims. In addition, it was predicted that CSA victims would score significantly higher than non-victims on scales assessing forms of empathic arousal associated with earlier stages of development. No significant differences between victims and non-victims were found and most victims reported a relatively high degree of recovery from their abuse experiences. This suggests that the adult victim's empathic responsiveness is not negatively effected by CSA given a high degree of recovery from the abuse.

DEDICATION

This work is dedicated to my grandparents who helped love me into the person that I am, especially my grandmother, Lola Slusser. She filled my heart and mind with many wonderful childhood memories and always treated me with "unconditional positive regard" as only grandmothers can. This work is also dedicated to all the children whose childhood memories are painful and traumatic because they do not have parents and grandparents like mine. This is especially for Rhonda, a sexually abused 8 year old, who had nobody to care and whose tears I will never forget.

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I want to thank all those who contributed their time and talents to the completion of this project. I am particularly grateful to Dr. L. Stewin for his willingness to supervise my work. He gave me the freedom to pursue my interests and provided the guidance, support, expertise, and encouragement that I needed. I sincerely appreciate the thoughtful contributions of the thesis committee members, Dr. J. Blakey and Dr. F. Snart. Special thanks to Janet Ryan who aided this project from beginning to end. Her insights, knowledge of the area, editorial skills, and most of all, her encouragement were invaluable. Laurie Sim and Judy Cameron contributed good ideas, editorial skills, and time. I am grateful to the participants who volunteered to be a part of the study. I especially appreciate the honesty and courage of CSA victims as demonstrated by their disclosure of these events. Most of all, I want to thank my family, especially my parents, Ray and Joanne Flickinger, and my sister, Beth Beaudoin. They have always supported and encouraged me, and have always been there.

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Chapter 1.

Introduction

> I am filthy. I am sick. People get nauseated when they see me. I belong in a hole where no one can be near me. I destroy everything I care for. I deserve to be beaten. I was bad. I am responsible for the unhappiness of all. I am the scum of the earth. I hate the very thought of me. (Grescoe, 1981, p. 25)

This was written by a teenage girl whose only "crime" was to do what an adult told her to do. She is a victim of child sexual abuse (CSA). We have witnessed in the last twenty years a heightening of public awareness of this phenomenon concurrent with an increased rate of reporting.

Research has explored various aspects of CSA, focusing primarily on initial and long-term effects, on those elements within an abusive situation that influence the degree of trauma experienced by the victim, and on factors that increase a child's risk for being abused. Both clinical and empirical research has shown that CSA can result in the kind of negative feelings and self-perceptions that were articulated in the quote of the teenager at the beginning of this chapter. Clinical data indicates that sexual abuse generally elicits negative emotional responses from the victim. The kinds of reactions most commonly seen are fear, anger and hostility, guilt, shame and depression (Finkelhor et al., 1986). These negative emotions form the lense through which the child views self and others.

What are the developmental consequences for a child who sees the

world in such a negative manner? Present research suggests the existence of long-term negative consequences of CSA in the areas of physical health, sexuality, self-esteem, emotional well being and social functioning for many CSA victims (Finkelhor et al., 1986). It is important to note that the experience of CSA does not inevitably lead to deficits, but that the abused child is at risk for suffering significant impairment in any or all of these areas.

The purpose of this study was to investigate the possible long-term effects of CSA on one particular aspect of social functioning; the development of empathy. Carl Rogers defined empathy as the ability "to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the 'as if' condition" (Rogers cited in Eisenberg & Strayer, 1987). Research has demonstrated that empathy appears early in the life cycle and is influenced by many factors in the individual's environment (Thompson, 1987). The role of empathy in relationships as well as moral development is an important one. The issue addressed in this study is the influence of being sexually abused as a child on the adult victim's ability to respond empathically.

It was hypothesized that CSA would have a negative effect by inhibiting the development of empathy to mature forms of expression. This possibility was explored by means of two questionnaires adminstered to a sample of university students. A standardized measure, the Interpersonal Reactivity Index (Davis, 1980), was used

to assess empathic responsiveness along four dimensions. The Personal Experiences Questionnaire, developed for this study, was used to differientiate between CSA victims and nonvictims.

The need for sound empirical research that employs standardized measures is emphasized in the CSA literature. The methodology of this study and the measures chosen were an attempt to respond to these needs as well as increase our knowledge concerning this important subject. The findings of this type of research have significant consequences for CSA victims and those seeking to help them. An increased understanding of the consequences of sexual abuse will enable professionals to assist victims in the process of recovery and will help in the prevention of sexual victimization.

Chapter 2 is a discussion of the relevant research, the rationale behind the present study, and the hypotheses that were tested. In Chapter 3, the study's design is outlined. Chapter 4 is a presentation of the results and statistical means used to analyze the data. In Chapter 5, the meaning and importance of the results are discussed, as well as, suggestions for future research.

Chapter 2

Review of the Related Literature

Empathy

There is much controversy in the empathy literature centering around the cognitive and affective components of empathy and the degree to which each plays a role (Mehrabian & Epstein, 1972; Bartnett, 1987). The first approach defines empathy in terms of a cognitive role-taking ability that permits the empathic person to predict accurately the emotions of another. There is an emphasis in this view on objectivity and accuracy. The second approach defines empathy as "a vicarious emotional response to the perceived emotional experiences of others" (Mehrabian & Epstein, 1972, p. 525). This second view emphasizes both the recognition and the sharing of another's emotional state. In this study, both aspects of empathy are considered.

The development of empathic capacity has been discussed by several authors who have attempted to integrate both the cognitive and affective components. Feshbach (1978) proposed a three-component model of empathy that requires "(1) the ability to discriminate and identify the emotional states of another, (2) the capacity to take the perspective or role of the other, and (3) the evocation of a shared affective response" (Barnett, 1987, p. 146). Hoffman's model emphasizes the effect of increased experiences and cognitive development on empathic arousal. He believes that as a

child's capacity to distinguish between self and other increases, the child will become more aware of the emotional experiences of others. For Hoffman, there is a strong connection between empathy and ego development (Hoffman, 1975, 1981, 1982; Barnett, 1987). Both of these models point to a number of internal factors that contribute to empathic responsiveness.

In a recent review of the literature, Barnett (1987) discussed the findings of research that have sought to elucidate external variables that contribute to the development of empathy. Environmental factors thought to be antecedents of empathic responsiveness include a secure relationship between child and caretaker (Mussen & Eisenberg-Berg, 1977; Waters, Wippman, & Stroufe, 1979), parental affection (Hoffman, 1982; Eisenberg-Berg & Mussen, 1978; Barnett, Howard, King, & Dino, 1980; Zahn-Waxler, Radke-Yarrow, & King 1979), empathic models (Barnett, King, Howard, & Dino, 1980; Coater, Pusser, & Goodman, 1976), an inductive style of parental dicipline (Zahn-Waxler et al., 1979; Dlugokinski & Firestone, 1974; Hoffman & Saltzstein, 1967), emphasis on the similarity between self and others (Bryant, 1982; Barnett, 1984), demphasis of competition (Barnett, Matthews, & Howard, 1979; Barnett & Bryan, 1974; Barnett, Matthews, & Corbin 1979; Stendler, Damrin, & Hines, 1951), and promotion of self-esteem (Strayer, 1980; Feshbach, 1982; Barnett, Thompson, & Pfeifer, 1985). There also appears to be gender differences with regard to empathy. Studies of adults and adolescents consistently demonstrate gender differences with

females scoring higher than males on empathy measures (Adams, 1983; Davis, 1983; Feshbach, 1982).

With regard to the present study, there are several researchers who have explored the relationship between negative childhood experiences and empathy. For example, Main & George (1985) investigated the effects of physical abuse on toddler's empathic arousal. They found that a control group of nonabused toddlers who came from disadvantaged families reacted to the distress of agemates "with simple interest or with concern, empathy, or sadness" (Main & George, 1985, p. 407). The authors noted that these are the responses that are typical of toddlers in general. The abused children responded quite differently.

> Not one abused toddler showed concern in response to the distress of an agemate. Instead, the abused toddlers often reacted to an agemate's distress with disturbing behavior patterns not seen in the control toddlers, such as with physical attacks, fear, or anger. Three of the abused toddlers alternately attacked and attempted to comfort peers found in distress. (Main & George, 1985, p. 407)

These findings are consistent with present theory concerning the development of empathy. It is hypothesized that when the child is in an environment that meets his or her emotional needs, he or she is able to be aware of and attend to the needs of others. Whereas, the child who's emotional needs are unmet remains comparatively unaware of others and their distress.

However, results from another study seem to contradict this idea.

Barnett and McCoy (1989) explored the relationship between distressful childhood experiences and empathy in college students. They found a positive correlation between the degree of reported distress experienced in childhood and measures of empathy. "Students who rated their distressful childhood experiences as highly distressing scored higher on both measures of empathy than did students who rated their experiences as relatively less distressing" (Barnett & McCoy, 1989). Interestingly enough, empathy was not related to the number of distressful experiences, but only to their intensity. The authors noted that both Feshbach (1978 & 1982) and Hoffman (1981) believed that distressful childhood experiences may enhance empathic responding to others in distress. According to their formulations, the key factor is not the number of distressing experiences, but rather "the extent to which a child is allowed or encouraged to experience the emotions associated with such occurrences" (Barnett & McCoy, 1989). While this appears to be a plausible explanation, there is no evidence to support it based on the results of the study.

In summary, the development and expression of empathy is influenced by many factors. Expressions of empathy appear early in the life cycle and are related to the child's relationship with caregivers, empathic models, social awareness, cognitive development, and distressful experiences. With respect to the latter factor, it is a basic assumption in this study that being sexually abused as a child is essentially a negative experience and is most

often perceived by the vicitm as distressful. In the next section, the evidence for this assumption and a model for understanding how victims are traumatized are presented.

Child Sexual Abuse

Child Sexual abuse (CSA) may be defined as "the sexual exploitation of a child who is not developmentally capable of understanding or resisting the contact, or a child or adolescent who may be psychologically and socially dependent upon the perpetrator" (B.C. Minstry of Human Resources, 1979, p. 1). Although sexual exploitation can assume many forms, the majority of research confirms that sexual abuse has a negative impact on children that often carries on into adulthood. The list of psychological and behavioral symptoms found among the abused is long. For children and adolescents, it includes:

> fear, compulsivity, hyperactivity, phobias, with drawal, guilt, depression, mood swings, suicidal ideation, fatigue, loss of appetite, somatic complaints, changes in sleeping and eating patterns, hostility, mistrust, sexual acting out, compulsive masturbation, and school problems. (Finkelhor et al, 1986, p. 235)

With respect to the long-term effects of CSA, both clinical and empirical research confirm that many women abused as children often manifest the following:

> depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency

> toward revictimization, and substance abuse . . . difficulty in trusting others and sexual maladjustment, such as sexual dysphoria, sexual dysfunction, impaired sexual self-esteem and avoidance or abstention from sexual activity. (Finkelhor et al, 1986, p. 162)

This is not a comprehensive listing, but it does demonstrate the existence of a wide array of possible effects.

David Finkelhor and Angela Browne (1986) outline a conceptual framework to explain the traumatic nature of child sexual abuse. They note four factors that they call traumagenic dynamics; powerlessness, betrayal, stigmatization, and traumatic sexualization. These factors represent the major issues that must be addressed by victims of CSA. Each may be seen as central theme representing a cluster of negative influences within a sexually abusive context. These categories are not mutually exclusive. There are some elements that are common to each. In addition, there is not a one-to-one correspondence with each of the four categories and the various effects of CSA. Some effects may be the outcome of several or all of the traumagenic dynamics.

The issue is further complicated by the existence of secondary problems that arise from the more primary symptoms of CSA (Courtois, 1988). However, there are certain effects that seem to be more or less related to a particular dynamic. These are discussed as well as those areas that appear to be common to each of the categories. In addition, developmental tasks specific to each dynamic are noted.

Powerlessness

In this context, powerlessness is defined as "'disempowerment,' the dynamic of rendering the victim powerless--refers to the process in which the child's will, desires, and sense of efficacy are continually contravened" (Finkelhor et al, 1986, p. 183). The developmental task within this category is efficacy (Wachtel, 1988). There are a number of different but related elements present when individuals are made to feel powerless. In CSA, the vulnerability of the child is exploited for the personal gratification of the offending adult. This exploitation occurs at several levels. There is both a physical and psychological violation of the victim's person.

Concerning physical violation Everstine & Everstine (1989) state:

> There are only three situations in which our bodies can be penetrated against our will: when we are shot, stabbed or raped. The involuntary penetration of this very primitive boundary causes the victim to experience a sense of not feeling whole (p. 68).

Although this statement applies to rape victims of all ages, it takes on new meaning when a child's body is violated against her will (see Footnote 1). Compared to a normal adult, the child has not had the

[1] The feminine pronoun is used throughout this paper in reference to the CSA victim. This is not to imply that males are not abused or that they are abused less frequently than females. The feminine pronoun was chosen because most of the CSA research has involved only females. In addition, the number of males disclosing sexual victimization in this study was too small to permit their inclusion in the analysis.

opportunity to form the same type of personal boundaries or self definition. In CSA, these physical and psychological boundaries are violated. The child has lost control of her body and other factors in the external world that directly affect her. She has also lost control of her internal world in that she may experience overwhelming emotions, such as confusion and fear, as a reaction to the abuse. In addition, erotic stimulation often results in a sense of losing control, which heightens a child's sense of helplessness.

At the heart of this process is the idea that control is a human activity. Humans survive by mastering the environment. When control is taken from us, we feel the loss of our humaness. In her research on childhood trauma, Terr (1990) notes that the loss of autonomy that occurs during a traumatic event results in feelings of terror for both children and adults. She explains this emotional response in light of the flight or fight response, which is a defensive reaction that prepares the individual to respond adaptively in threatening situations. When we are threatened, our bodies mobilize for action. Trauma occurs when we are ready to act in the face of danger and are prevented from doing so because we cannot succeed. Autonomy has been lost and it is replaced by extreme fear and often rage.

Shame is another reaction to being rendered helpless. Wurmer defines shame as "a response to exposure, an emotional response impelling us to hide" (Wurmser as cited in Nathanson, 1989, p. 318). Terr notes the interplay between shame and guilt in trauma victims. In order to protect themselves against the pain of shame resulting

from being made less-than-human, children take on guilt. They deny the reality of their helplessness and assume responsibility for what has occurred. They come to believe that they have somehow caused the traumatic event(s) and are therefore guilty, but not as helpless as they were before. This tradeoff has the effect of lessening the pain of dehumanization at the cost of distorting reality.

Powerlessness is also associated with low self-esteem, anxiety, identification with the aggressor, heightened need for control, a victim mentality, and pessimism concerning the future (Finkelhor et al, 1986; Terr, 1990). Behaviorial manifestations may include phobias (Alter-Reid et al., 1986), nightmares (Shapiro, 1987; Briere, 1984), somatic complaints (Meiselman, 1978), disassociation, depression (Gorcey et al., 1986; Justice & Justice, 1979; Rew, 1989a &1989b), interpersonal difficulties (Porter et al., 1982), revictimization, and anti-social behavior (Finkelhor et al, 1986).

Betrayal

Betrayal is defined as "the dynamic in which children discover that someone on whom they are vitally dependent has caused them harm" (Finkelhor et al, 1986, p. 182). Within the betrayal dynamic, "trust relationships" are the developmental issue (Wachtel, 1988, p. 32). Betrayal may occur in different ways in an abusive situation. Not only has the child been exploited and objectified by the offender but she has not been protected by her caretakers. Her sense of betrayal deepens if her disclosure of the abuse is not believed or the child is

blamed for the abuse and she remains unsupported. In the abusive situation, the child's perceptions and emotions are negated continually. The trust and vulnerability of the child have been violated for the personal satisfaction of another.

The resulting emotional response depends on how deeply the child feels betrayed. It may include anger, frustration, hostility, grief, depression, and mistrust. Other consequences include extreme dependency and an inability to assess the trustworthiness of others. In addition, mistrust often results in a tremendous fear of abandonment (Friel & Friel, 1988). Often the pain of betrayal is so great that the victim will assume responsibility for the abuse, thereby incuring a sense of guilt. As with shame, it is an "emotional tradeoff" and a reality distortion that attempts to avoid a greater psychic pain. This is discussed further in the next section.

Behaviorial manifestations of the betrayal dynamic include; revictimization (Russell, 1986), clinging and excessive dependency, isolation, problems with intimacy (Steele & Alexander, 1981; Courtois, 1979), aggressive and anti-social behavior (Herman & Hirschman, 1977; Porter et al., 1982), and a failure to protect one's own children (Finkelhor et al, 1986; Justice & Justice, 1979; Katan 1973).

Stigmatization

Stigmatization "refers to the negative connotations--for example, badness, shame, and guilt--that are communicated to the child about

the experiences and that then become incorporated into the child's self-image" (Finkelhor et al, 1986, p. 184). Self-concept is the developmental issue related to stigmatization (Wachtel, 1988). There are many ways in which negative messages are communicated to the child. The victim may be denigrated by the offender or blamed for the occurrence of the abuse. The child may feel guilty for having participated in a taboo activity. Others may come to view the victim in a negative manner (i.e. "damaged goods") because of the abuse. The secrecy that generally surrounds the abuse also conveys a sense of badness, shame, and differentness. The impact of secrecy can be particularly traumatic if threats and coersion are involved (Lister, 1982).

As stated in the first two sections, there are often emotional tradeoffs that occur which result in self-blame and guilt. For example, it may be easier for a child to believe that she is a "bad girl" and therefore, deserves the abuse, than to believe that her parent is not able to care for her in a healthy manner (Friel & Friel, 1988).

The psychological impact of these factors often results in low self-esteem (Bagley & Ramsay, 1986; Rew, 1989a) and a sense of shame, guilt (Justice & Justice, 1979) and alienation (Courtois, 1979). These may then result in self-destructive behaviors, such as substance abuse, social isolation, and further victimization (Sedney & Brooks, 1984; Alter-Reid et al., 1986).

Traumatic Sexualization

Traumatic sexualization is defined as "a process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of the sexual abuse" (Finkelhor, 1986, p. 818). Sexuality is the developmental issue within this dynamic (Wachtel, 1988). There are again a variety of ways in which traumatic sexualization can occur. The child may be rewarded for sexual behavior and learn to use this as a means to manipulate others or to satisfy other emotional needs. The victim may begin to view sex and affection or nuturing as being the same. As a result, she may not learn to relate to others in a nonsexual manner and be unable to distinguish between sexual and nonsexual touching (Yates, 1987). In addition, the child may rely exclusively on sexual activity as a way of handling stress. Tramatic sexualization also occurs when fear and other negative emotions become associated with sex and/or when certain parts of the child's body are the focus of adult attention. The child's concepts concerning appropriate sexual behavior and morality are also affected (Finkelhor et al, 1986).

The psychological effects of traumatic sexualization may include an increased concern and preoccupation with sexual matters; confusion about sexual identity, sexual norms, and of equating sex with nurture; the association of negative emotions and memories to sexual activity; and an aversion to intimacy or sex (Finkelhor et al., 1986; Finkelhor et al., 1989). These may manifest behaviorially in

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precocious, aggressive, or promiscuous sexual activity (Brunngraber, 1986; de Young, 1982); in sexual addictions and dysfunctions, and in an avoidance or phobic responses to sexual activity (Lukianowicz, 1972; Finkelhor et al., 1986).

In summary, both clinical and empirical research in this area confirm the existence of the negative effects on the victim of CSA. The traumagenic model is a way of conceptualizing the impact of CSA on the developing child. Elements unique to each situation affect the degree to which a child is traumatized in these areas. Some of the factors that have been found to affect the degree of trauma include the duration and frequency of the abuse; the type of sexual activity; the use of force or coersion; the victim's age; the age, gender and relationship of the offender; the active or passive participation of the victim; reactions of parents and others when abuse is disclosed; and the institutional response (Courtois, 1988). Based on this model, it is evident that the relationship between CSA and emotional development is complex. The following discussion integrates these two areas and outlines the focus of this study and the rationale behind the means used to investigate this area.

An Integration

In a recent study entitled "Long-term effects of childhood sexual abuse in the empathy-deficient schemas of adolescent girls," Roxanna Wolfe (1989) investigated the relationship between CSA and deficits in interpersonal functioning. Based on the theories of Piaget and

Sullivan, Wolfe contended that "empathy evolves in the process of sharing feelings and experiences" (Wolfe, 1989, p. 38). It is the product of healthy interpersonal relationships. Children begin this process by learning about the social world first through their relationships with parents and later through their peers. In adult-child relationships, adults define the reality of the child who will conform to the system presented by the adult. Within a healthy adult-child relationship, the child's needs are met by the adult. This conveys a sense of respect for and affirmation of the child as a person. What occurs in an abusive context is quite different because the child is forced to meet the needs of the adult.

> The breaking down of role boundaries which occurs in a sexually abusive relationship goes beyond the misuse of power and disregard for the needs of the child. Intimacy is disrupted in its formative stages with the demand that the child respond to the needs of the others. This is developmentally inappropriate both in social context and cognitive and affective stage preparedness. (Wolfe, 1989, p. 36)

This developmental disruption has two consequences important for the development of empathy. The first is that in order to survive in an abusive relationship with an adult, a child will often become hypervigilant concerning the cognitive and affective states of others in order to be able to anticipate their behavior. This ability could conceivably be classified as a form of empathy, but Wolfe did not comment on this possibility.

There are several reasons why hypervigilance cannot be viewed as

a mature form of empathy. First of all, it develops as a means of defending or protecting the child and is in this sense a defense mechanism. Although hypervigilance may allow the child to ascertain the emotional state of another, it seems likely that there will be some distortion of reality as is the case with other defense mechanisms. The reason for the distortion is that the motivating force behind the development of hypervigilance is fear and mistrust, which would inevitably color the child's judgment. It must also be noted that in an abusive relationship, the child's inner world is continually negated. The child learns that her emotions are not to be trusted and can be dangerous to survival. Hense, the child learns to repress emotions and to deny others access to her inner world. It is this emotional distancing from both the self and others which accompanies hypervigilance that prevents it from being considered a mature form of empathy.

The second consequence of disrupting primary forms of intimacy is that the child is unable to enter into reciprocal relationships with peers; the next phase of social development and the foundation of mature empathic responsiveness. The reason for this inability is due to the nature of peer relationships. They are reciprocal in that they involve the sharing of ideas, emotions, and experience. The CSA victim is cut off from this type of interaction by her abuse "secret", a lack of self-knowledge, and an inability to allow others to access the self. In the abusive context, it is not safe for the child to learn these skills. In short, it is likely that victims of CSA will be unable to

share themselves with others when opportunities for intimacy are available. The effect of the lack of reciprocal relationships on the development of empathy is profound on the CSA victim.

> Without the co-construction of knowledge characteristic of adolescent development, her knowledge of self and other is incomplete. She may also have lost opportunity to join in the active learning motivated by peer interaction. Furthermore, her awareness of the agency of self-and-other is limited. She is at risk of having limited ability in knowing the motive or reasoning behind another's actions. As a result, her future relationships are at risk of reproducing the distorted asymmetrical interaction of her victimization. (Wolfe, 1998, p. 40)

Based on these factors, Wolfe concluded that CSA results in empathy-deficient schema for the victims. Her research lends further evidence to this theory. Wolfe used the Impact Message Inventory (IMI), which identifies participants interpersonal style, to compare three groups of adolescent females; clinical setting (CSA), clinical setting (non-CSA), and natural school environment. It was found that adolescents from both clinical groups scored significantly higher on two IMI scales (Hostile and Submissive) than did adolescents from the natural school environment. The hostile interactional style is characterized by hostility, mistrust, and detachment. The submissive style is characterized by docility, appeasement, lack of iniative, and self-abasement. Neither of these interpersonal styles is conducive to reciprocal relationships between equals "marked by the comingling of self-knowledge and

understanding of the other" (Wolfe, 1989, p. 38).

Although the CSA and non-CSA participants from the clinic did not differ from each other on the IMI measure, there were differences found in the semi-structured interview. Wolfe reported that:

> Differences appear to be greater in two areas: (a) their ability to access feelings of others, and (b) their ability to allow others access to their own. The non-CSA girls expressed difficulty in both areas. In contrast, for the CSA group, accessing the affective state of others seems highly developed, while their willingness to let other's have access to their affective state is severely limited. (Wolfe, 1989, p. 102)

Unfortunately, Wolfe's study is methodologically limited in that all CSA victims came from a clinical population. There was no attempt to determine whether adolescent participants from the natural school setting had been sexually abused and no attempt identify and form a group of CSA victims from this setting. This prevents Wolfe's conclusions from being generalized to the larger population of CSA victims. One of the goals of the present study is an attempt to address this issue.

The purpose of this study is to examine whether a relationship exists between empathic arousal as an adult and being abused sexually as a child, and to explore the nature of such a relationship. By looking at personality factors associated with both empathy and CSA, it was possible to make some predictions concerning their relatedness.

The self-report measure that was used in this study was the

Interpersonal Reactivity Index (IRI) (Davis, 1980). It has been demonstrated that the IRI measures four different but related aspects of empathy (Davis, 1983). The measure includes four scales each consisting of seven questions. The scales reflect four different ways of responding to others. They are based on factors associated with empathic responsiveness that have been identified in previous theory and research. Its author notes that "the content domain of each of these four scales fits the general definition of empathy as a reaction to the observed experiences of another" (Davis, 1983, p. 114).

The Perspective-Taking (PT) scale is thought to measure the degree to which a person is able to view a situation from another's psychological perspective and therefore, assesses the cognitive dimension of empathy. Perspective-Taking has been shown to be positively correlated with social competency and self-esteem, although the correlation is moderate. Davis notes that the moderate strength of the relationship may indicate that other factors are involved in social competency other than perspective taking. This would also hold true for the relationship between perspective-taking and self-esteem. Perspective-taking was shown to be negatively related to measures of fearfulness and of emotionality. Two measures of sensitivity to others were also correlated with the PT scale. The Public Self-Consciousness subscale (Fenigstein, Scheier, & Buss, in Davis, 1983) is self-oriented in that it measures the degree to which a person is aware of others' perceptions of him or her. The Personal Attributes Questionnaire's F scale (Spence, Helmreich, &

Stapp, in Davis, 1983) is more other-oriented and assesses personal concern for the feelings and needs of others. While PT proved to be negatively related to the self-oriented measure, it was positively correlated to the more other-oriented scale of sensitivity to others. As with social competency and self-esteem, all of the correlations are moderate.

The Fantasy scale (FS) assesses the degree to which respondents tend to "transpose themselves imaginatively into the feelings and actions of fictitious characters in books, movies, and plays" (Davis, 1983, p. 114). In general, FS scores were found to be unrelated to measures of social functioning and self-esteem, but positively related to chronic emotionality and to both self and other oriented measures of sensitivity to others.

The Empathic Concern (EC) scale "assesses 'other-oriented' feelings of sympathy and concern for unfortunate others" (Davis, 1983, p. 114). Empathic Concern tends to be associated with anxiety or a lack of comfort in social situations, emotional vulnerability, insecurity and fearfulness. However, EC scores were negatively correlated with measures of loneliness, boastfulness, and egoism. Lastly, EC was shown to be positively related to "other-oriented" measures of social sensitivity.

The Personal Distress (PD) scale "measures 'self-oriented' feelings of personal anxiety and discomfort in tense interpersonal settings" (Davis, 1983, p. 114). A modest negative correlation was found between the PD and PT scales. The PD scale demonstrated a

modest positive correlation with self-oriented measures of social sensitivity. This indicates that those obtaining high scores on the PD scale are concerned about how they are evaluated by others. In addition, Davis reported that the PD scale "seems to be associated with a strong tendency toward a particular type of emotionality--one characterized by fearfulness, uncertainty, and vulnerability" (Davis, 1983, p. 121).

The relationships between the scales have proven to be consistent with Hoffman's theory of the development of empathy (cited in Davis, 1983). He proposed that young children are unable to adopt the perspective of another because of a lack of cognitive development. Therefore, they perceive another's distress as their own and are unable to differentiate between the two. They respond to the distress of others by becoming distressed themselves. As children develop intellectually, they are able to differentiate between the self and others, and are able to adopt the perspective of another. As development continues, earlier feelings of distress and "personal unease are transformed into more other-oriented feelings of sympathy and concern" in response to another's distress (Davis, 1983, p. 116). Several of the correlations between the scales are consistent with this theory in that Perspective-Taking and Empathic Concern (which is other-oriented) show a moderate positive correlation (mean r = .33). Whereas, Perspective-Taking and Personal Distress (which is self-oriented) show a modest negative correlation (mean r = -.25). Fantasy is positively related to Empathic Concern

(mean r = .33), but its relationship to the other scales is insignificant for females.

Based on these observations, it was possible to predict the responses of CSA victims on the IRI measure. It is clear from research in the area of CSA that victims often experience difficulty in interpersonal relationships and struggle with low self-esteem as well as feelings of alienation and fear, (Finkelhor et al., 1986). Because the Perspective Taking scale is negatively related to all of these characteristics, it was predicted that CSA victims would tend to score lower on this scale than those who had not been abused.

Although some CSA victims use fantasy as a psychological defense during and after abusive episodes, it is not clear as to whether victims generally tend to fantasize more than non-victims about fictious characters. However, it seems likely that the use and strength of this defense mechanism would enable victims to more readily fantasize about fictious characters than non-victims. For this reason, it was predicted that scores on the Fantasy scale would be significantly higher for victims than non-victims.

Responses on the Empathic Concern scale were difficult to predict. High scores on this scale are associated with social anxiety, emotional vulnerability, insecurity and fearfulness. However, Empathic Concern is negatively correlated with loneliness. All of these characteristics have been shown to be associated with the experience of CSA. Therefore, it was uncertain how CSA victims would respond on this scale based on these factors. However, in light

of the positive relationship between the PT and EC scales, it was predicted that CSA victims scores would be significantly lower than non-victims.

On the Personal Distress scale, it was predicted that CSA victims would score significantly higher than non-victims. High scores on the PD scale are associated with lower social competence (which include feelings of loneliness and social anxiety), lower self-esteem, and emotional vulnerability (particularly fearfulness).

Finding a pattern of high scores on the Personal Distress and Fantasy scales and low scores on the Perspective-Taking and Empathic Concern scales among CSA victims would have certain implications about the development of empathy in light of Hoffman's theory. In particular, the Personal Distress scale is associated with earlier stages of the development of empathy and the Perspective-Taking scale with greater maturity. Finding that CSA victims score significantly higher on the Personal Distress scale and significantly lower on the Perspective-Taking scale than non-victims would suggest that CSA affects the development of empathy by inhibiting its progression to more mature forms of response, which is consistent with Wolfe's theory on the interpersonal impact of CSA.

However, there are several possible confounding variables in this study that must be considered. The first factor is the effect of distressful childhood experiences other than sexual abuse. The effect of this factor is to increase empathic responsiveness (Barnett & McCoy, 1989), which could obscure the true relationship between CSA

and empathy. The influence of this variable had to be addressed in order to measure accurately the relationship between CSA and empathy. The second possible confounding factor is the degree to which the CSA victim has recovered from the trauma. The effect of this variable would serve to attentuate the predicted relationship between CSA and empathic responsiveness. It seems likely that CSA victims who have experienced a greater degree of recovery from the trauma of the abuse would demonstrate greater empathic responsiveness than those who have experienced little or no healing. For this reason, measures of these two variables were included so that their impact on empathy could be determined.

Hypotheses

On the basis of the literature reviewed, the following hypotheses were formulated:

1. CSA victims will score significantly lower than non-victims on the Perspective-Taking and Empathic Concern Scales.
2. CSA victims will score significantly higher than non-victims on the Personal Distress and Fantasy scales.
3. Females will score significantly higher than males on each of the four empathy scales.
4. Performance on the IRI will not be affected significantly by class membership (i.e. course taken).

Chapter 3

Experimental Design

Method

Definition

In this study, sexual abuse is operationally defined as "any self-reported contact (e.g., fondling to intercourse) experienced by a client before the age of 15 years, initiated by someone five or more years her senior" (Briere & Runtz, 1988, p.53) or forced sexual contact with a peer(s) before the age of 17 years. This is a conservative definition as compared to other possible definitions used in sexual abuse research. It was chosen because it emphasizes the youth of the victim and the power differential that exists between an adult and a child. Sexual experiences that occured between children or adolescents relatively close in age were included only if there was violence or force involved. Experiences in which a child is exposed to a sexual act were not included. Although experiences like these can be extremely traumatic in nature, they were not included so that the definition of sexual experiences would be as conservative as possible.

Subjects

One hundred and thirteen undergraduate and graduate students enrolled in educational psychology courses and one theology course, at the University of Alberta, were asked to participate as volunteers in

the study. Four participants chose not to complete the second questionnaire and two participants did not indicate their gender. Therefore, the answer sheets from these six subjects were not included in the data analysis, leaving a total of ninety females and seventeen males. The one exception is the analysis involving class membership. The two participants who did not indicate gender were included in this analysis because gender was not a factor.

Of the one hundred and seven participants, 29 females and 2 males indicated that they had been sexually abused as children (CSA), 28 females and 6 males indicated that they had experienced distressful events during childhood other than sexual abuse (DCE), and 33 females and 9 males reported no incidence of CSA or other distressful experiences (no CSA/DCE). See Table 1. Other characteristics of the sample are included in Table 2 (sex and class membership) and Table 3 (sex and age).

Table 1

Characteristics of the Sample by Sex and Group Membership

Group	Males	Females	Total
CSA	2	29	31
DCE	6	28	34
No CSA/DCE	9	33	42
Total	17	90	107

Table 2

Characteristics of the Sample by Sex and Class Membership

Class Membership	Males	Females	Total
Ed. Psych. 163 Development	4	21	25
Ed. Psych. 417 Religious and Moral Development	3	28	31
Ed. Psych. 493 Basic Issues in Contemporary Education	4	17	21
Ed. Psych. 501 Methods of Educational Research	1	7	8
Ed. Psych. 597 Counselling Through Crisis	0	5	5
Christian Theology 431 Sex and Marriage	5	12	18
Total	17	90	107

Table 3

Characteristics of the Sample by Sex and Age

Age	Males	Females	Total
17-20 years	1	11	12
21-30	15	50	65
31-40	1	17	18
41-50	0	10	10
Total	17	88	105

2 cases omitted from n = 107 due to missing data

Instruements

The Interpersonal Reactivity Index was used to assess empathic responsiveness (Davis, 1980). This questionnaire consists of 28 statements. Participants are asked to indicate how well each statement described them by choosing the appropriate letter on a scale at the top of the page. The letters range from A (does not describe me well) to E (describes me very well) on a Likert type scale. See Appendix A. Answers were recorded on a computer answer sheet. Letters A through E were given numeric values (e.g. A=0, E=4). Eight forced negative items are interspersed throughout the

questionnaire to deal with fixed response set. The numerical weighting of these eight items is reversed at the time of scoring. Each participant's scores are calculated by totaling the responses on each of the four scales.

Davis notes the "excellent psychometric properties" of this instrument when he writes: "The factor structure remains constant for both sexes across independent samples and across repeated administration. In addition, the internal reliability of the four scales is quite acceptable" (Davis, 1980, p. 14). See Table 4 for internal reliability coefficients (standardized alpha) for each of the four subscales. See Table 5 for test-restest reliability coefficients.

Table 4
Internal Reliability Coefficients (standardized alpha) for the 7-item, unit-weighted scales.

Gender	Fantasy	Perspective-Taking	Empathic Concern	Personal Distress
Males	.78	.75	.72	.78
Females	.75	.78	.70	.78

Table 5
Test-Retest Reliability Coefficients for the Four Empathy Subscales (Interval Between First and Second Administration of the Questionnaire from 60 to 70 Days)

Gender	Fantasy	Perspective-Taking	Empathic Concern	Personal Distress
Males	.79	.61	.72	.68
Females	.81	.62	.70	.76

n = 56 males, n = 53 females

The Personal Experience Questionnaire was used to determine whether or not participants had been sexually abused as children and the degree to which they found these experiences traumatic in nature. The questionnaire consists of an explanation of how sexual contact is defined in this study and has four questions about childhood sexual experiences, two questions about other distressful childhood experiences, one question concerning recovery from trauma, and one self-rating of empathy. See Appendix B.

Procedure

All procedures were approved by the Ethics Committee of the Educational Psychology Department prior to beginning the project. Students were asked to participate in the study on a voluntary basis. They were told that participation included filling out two questionnaires and that they were free to discontinue participation at

any time if they wished. The researcher explained that the first questionnaire consisted of 28 statements about their thoughts and feelings in various situations. They were asked to rate how well each statement described them. They were told that the purpose of the study would be explained after they had completed the first questionnaire because this knowledge might influence their responses. Therefore, participants were encouraged to quickly read over the questions on the first questionnaire and then decide if they desired to participate in filling out the first questionnaire. They indicated their willingness to participate by answering the questions. They were told that if at any point during the session they did not wish to participate in the study, they could write their intention not to participate on the top of the questionnaire and/or not answer any of the questions.

Participants were assured that their answers would remain anonymous and were encouraged to be as honest as possible. They were instructed not to put their names or student ID numbers on the questionnaires or the computer answer sheets. After these instructions, they were given the Interpersonal Reactivity Index and a computer answer sheet on which to record their answers.

When participants completed the IRI, the purpose of the study was explained in terms of exploring the relationship between childhood sexual experiences and the adult's empathic responsiveness. The researcher stated the following: "The purpose of this study, is to explore the relationship between childhood sexual experiences and the

development of empathy. It is now known that many people have had sexual experiences as children. Some of these experiences are very disturbing and painful, and others are not. Unfortunately, relatively little is known about the effects of early sexual experiences. In order to promote health in this area for both children and adults, more information is needed. In this last questionnaire, you are asked to answer seven questions" (Finkelhor et al., 1986; Alter-Reid, 1989). The researcher read the questions from the Personal Experiences Questionnaire and then stated: "We are not asking for any details of experiences that you may have had as a child. We simply need to know whether or not you have had such experiences and how you have felt about them. Please remember that your answers will remain anonymous and that your honesty will help us understand this important area."

Participants were then given the Personal Experiences Questionnaire. After the questionnaires were completed and all materials collected, participants were debriefed and encouraged to contact the researcher at the Education Clinic if they had any questions or concerns related to the area. See Appendix C.

Chapter 4

Results

Independent two-tailed t tests, one-way analysis of variance, and linear regression were used to analyze the data on the self-report measure of empathy (IRI). This was accomplished by means of the Statistical Package for the Social Sciences (SPSSX) computer program (1983).

Hypotheses 1 and 2

An independent two-tailed t test was used to analyze the data from female participants (CSA victims vs nonvictims). No significant differences were found between these two groups. See Appendix D Table 1. Other comparisons for female participants were made by means of a one-way analysis of variance. The first comparison included three groups; CSA victims (CSA), nonvictims with other distressful childhood experiences (DCE), no CSA/DCE (Appendix D Tables 2a-2d). The second comparison included four groups; CSA, DCE, CSA/DCE, and no CSA/DCE (Appendix D Tables 3a-3d). No significant differences were found. This suggests that group membership was not a significant influence on participant's performance on the empathy measure.

Two multiple regression models were tested and the results compared in order to address the possibility that confounding variables may have masked the effect of group membership (CSA vs

DCE vs no CSA/DCE vs CSA/DCE) (Appendix D Table 5). In the first model three possible predictor variables were included; degree of CSA trauma, degree of DCE trauma, and degree of recovery. The percentage of variance accounted for by this equation was low on each scale; Fantasy r^2 = .02, Empathic Concern r^2 = .03, Perspective Taking r^2 = .03, and Personal Distress r^2 = .02. In the second model, CSA and DCE group membership were added to the three predictor variables as two dummy variables. In this equation, the percentage of variance accounted for was again low; Fantasy r^2 = .03, Empathic Concern r^2 = .09, Perspective Taking r^2 = .03, and Personal Distress r^2 = .03. A comparison between the regression coeffients on all four scales show little if any change. This indicates that group membership did not contribute significantly to the explained variance on each scale.

Hypothesis 3

Independent two-tailed t tests were used to compare males and females on the four empathy scales: Fantasy (FS), Empathic Concern (EC), Perspective Taking (PT), and Personal Distress (PD). See Table 6. On the Fantasy scale, the mean for males (M = 13.12, S = 5.26) was significantly lower than the mean for females (M = 17.51, S = 5.61), $t(105) = -2.99$, $p \leq .05$. On the Empathic Concern scale, the mean for males (M = 17.65, S = 6.18) was significantly lower than the mean for females (M = 22.1, S = .47), $t(105) = -3.53$, $p \leq .05$. There were no significant differences between males and females on the

Perspective Taking scale. On the Personal Distress scale, the mean for males (M = 7, S = 4.53) was significantly lower than the mean for females (M = 11, S = 5.28), $t(105) = -2.92$, $p \leq .05$.

Table 6

Means, Standard Deviations and Significance of Differences Between Males and Females on Four Scales of IRI Measure

Scale	Male		Female		t-value	Prob.
	M	SD	M	SD		
Fantasy	13.12	5.26	17.51	5.61	-3.13	.005*
Empathic Concern	17.65	6.18	22.10	4.47	-2.83	.011*
Perspective Taking	18.59	7.26	19.00	4.32	-0.23	.823
Personal Distress	7.00	4.53	11.00	5.28	-3.25	.003*

n males = 17. n females = 90.
*$p \leq .05$, two-tailed.

Hypothesis 4

A one-way analysis of variance was used to determine the effect of class membership on the four empathy scales. See Appendix D Table 4a-4d. No significant differences between classes were found.

Internal Consistency

The response data for participants (n = 109) was analyzed for internal consistency within each scale (Cronbach's Alpha Coefficient). The resultant correlation coefficient for each scale is as follows: Fantasy scale, r = .82; Empathic Concern, r = .85; Perspective Taking, r = .83; and Personal Distress r = 82. This suggests a high degree of internal consistency between the items within each scale and is congruent with Davis' findings.

Chapter 5
Discussion

In general, the data do not confirm the hypotheses. It was predicted that CSA victims would score higher on the Fantasy and Personal Distress scales and lower on the Perspective Taking and Empathic Concern scales than non-victims. These predictions were based on personality factors associated with the four scales on the Interpersonal Reactivity Index (IRI) and CSA. Significant differences between CSA victims and nonvictims were not found. Other comparisions were made (CSA victims (CSA) vs nonvictims with other distressful childhood experiences (DCE) vs no CSA/DCE) (CSA vs DCE vs CSA/DCE vs no CSA/DCE) in which no significant differences were found.

Due to the fact that certain confounding variables may mask the effects of group membership, two regression models were constructed. The first included degree of CSA trauma, degree of DCE trauma, and degree of recovery. The second model included all of the variables in the first model and group membership (CSA vs DCE vs CSA/DCE vs no CSA/DCE). The percentage of variance accounted for by these variables was quite low in each model. A comparison between the two models showed that group membership did not contribute significantly to responses on the empathy measure. Therefore, the hypothesis that CSA will affect responses on the empathy measure must be rejected.

Significant differences between males and females were found on three of the scales. Females scored higher than males on Fantasy, Empathic Concern and Personal Distress scales. This finding is consistent with the results of other studies measuring adult empathy and with Davis' research using the IRI measure (1980). A significant difference between males and females was not found on the Perspective Taking scale. It is likely that Perspective Taking is more closely related to cognitive development than are the other scales. If this is true, it is not surprising that differences between males and females are insignificant. Although Davis found significant differences on all the scales, the least amount of difference was found on the Perspective Taking scale. In addition, a lack of significant differences found between classes is an indication of homogeneity within the sample.

Failure to find the predicted effects of CSA in the present study may have occured for the following reasons. The first possibility that might explain these findings is that being sexually abused as a child does not affect the adult's empathic responsiveness or that CSA affects empathy differently than the theoretical position taken in this study. Given the results of past research in the areas of CSA and empathy, it is unlikely that there is no relationship between abuse and empathy. However, the difference between the groups accounted for by group membership was low enough to be negligible. This finding cannot be ignored in light of the excellent psychometric properties of the IRI measure (Davis, 1980 & 1983). It is possible

that empathic responsiveness is affected by CSA in a manner not addressed by this study. For example, Barnett et. al. (1986 & 1987) conducted two studies involving female undergraduates that examined the relationship between similarity of experience and empathic responding. The results showed that females who had been raped displayed more empathy toward a rape victim than females who had not been raped. However, the differences in empathic responsiveness between the two groups did not generalize to other situations. Similarity of experience was the key factor in determining differences in empathy. These results lead to the conclusion that empathic responsiveness may be specific to a particular situation and depend on a person's past experiences, which enable him or her to identify with the experience of another.

Another way of viewing empathy with respect to abused children is that empathic responsiveness may increase toward nonhuman objects, while appearing to decrease toward people. Judy Godby (personal communication, June 10, 1989) has noted that in her experience as a counsellor working with sexually abused children and adults, abused children often exhibit less concern for family members and increased concern for the welfare of a pet or animals in general. The possibility of "selective empathy" with regard to both situation and object makes its relationship to CSA difficult to determine. The measures used in this study were not designed to address this issue. Nevertheless, "selective empathy" may more accurately define the relationship between CSA and empathic responsiveness.

A second possible explanation of the results of the present study is that the questionnaires used to measure empathy and assess childhood experiences may not have been sensitive enough to discern a complex relationship. The Personal Experiences Questionnaire is a crude measure for determining type and severity of childhood trauma, as well as, recovery from traumatic experiences. It does not differentiate between trauma experienced at the time of the event and distress experienced later in life because of the event. The method of inquiry (e.g. collecting sensitive data in a group situation and limited time factor) did not permit a more thorough disclosure as to the nature of victims' experiences, which may have illuminated the present findings.

Determining the type of abuse to be studied is a crucial issue in CSA research. There are numerous definitions of CSA. The important consideration is that the definition alone can make a tremendous difference in the results of a study. An example of how differing definitions can radically alter the findings of research can be seen in the results of two studies. Both Fromuth (1986) and Briere and Runtz (1988) used the Hopkins Symptom Checklist to examine the relationship between CSA and general symptoms of psychopathology. such as depression and anxiety. Briere and Runtz modified the Checklist by using only 5 of the 8 HSCL scales (Interpersonal Sensitivity, Obsessive-Compulsive, Depression, Anxiety, and Somatization). They also added a Dissociation scale. Both studies enlisted the participation of female undergraduate students enrolled

in introductory psychology courses. In spite of the similarities between these two studies, the results were quite different. Fromuth found no significant differences between abused and non-abused students, except for a slight relationship for phobic anxiety. In contrast, Briere and Runtz found that victims "reported higher levels of dissociation, somatization, anxiety and depression than did nonabused women" (Briere & Runtz, 1988, p. 51).

The only major difference evident between the two studies was that Fromuth used a more inclusive definition of abuse in that nonphysical events were included. Present research suggests that nonphysical events are not typically associated with long-term effects (Finkelhor et al., 1986). A more conservative definition was used in the Briere and Runtz study. Nonphysical events were excluded. The comparison of these two studies illustrates the importance of the definition of abuse and the possible effect it can have on the results of the study.

Another problem frequently encountered in the CSA research that pertains to this study is the use of self-report measures. Participants may not report accurately due to a certain reluctance and/or inability (e.g. memory lapse) to do so. It is not unusual for individuals who have been sexually abused as children to not remember the experience as an adult. The inaccuracy of the measures used and inaccuracy of the self-report method would attenuate any relationship between CSA and empathy. Therefore, any error in the results due to unreliability would serve to obscure relationships.

A third possibility is that the CSA victims in this study are not representative of the population of CSA victims and/or the sample size may be too small. The majority of CSA participants and those who had other distressful childhood experiences estimated their degree of recovery from these events as being quite high. Out of the forty-seven females who rated their recovery, thirty-seven (79%) indicated that the past event(s) has little or no effect on them presently. Nine participants rated their recovery as being in the midrange (i.e. "I have experienced some recovery and feel that the event(s) still is a negative influence in my life."). Only one participant indicated that she frequently felt that the event(s) affected her life "significantly in negative ways." None of the participants rated their recovery as being at the lowest possible level (i.e. "I have experienced little recovery and feel that the negative impact of the event(s) affects my life most of the time.").

This high recovery rate may be a relatively accurate estimate and/or reflect a lack of self-awareness or denial. The answer is likely to be some combination of these possiblities. The implications of this finding along with the fact that participants were university students suggest that the present level of functioning is relatively high for CSA victims in this study. Those struggling significantly with the long term effects of CSA do not appear to be represented in this group. Those at the upper end of the population of CSA victims in terms of coping ability may exhibit little or no difference in empathy when compared with non-victims.

If degree of recovery is an important factor in the development of empathy, the lack of representativeness within this sample may mask the true nature of the CSA/empathy relationship. The are several ways in which this could happen. In chapter two, it was noted that degree of recovery had the potential of obscuring relationships. The reason for this is that CSA victims who have experienced a greater degree of recovery from the trauma of the abuse are likely to demonstrate greater empathic responsiveness than those who have experienced little or no healing. Unfortunately, the sample size in this study does not permit an investigation of this assumption. As stated earlier, there were not enough participants reporting lower levels of recovery.

It also seems likely that the degree to which a person has been traumatized by the abuse would affect empathic responsiveness. This could be construed as a linear relationship with either a positive or negative correlation. For example, an increase in the degree of childhood trauma results in an increase in adult empathy. However, it may also be the case that empathic responsiveness is affected differentially by degree of trauma, in that there may be a curvilinear relationship rather than a linear one. It has been found that the human psyche can become overwhelmed and immobilized by trauma (Lifton, 1984). This response has been called "psychic numbing" and refers to "a kind of mental anesthetization that interferes with both judgment and compassion for other people" (Lifton, 1984, p. 4). Psychic numbing serves to insulate the mind from the trauma of the

event itself and from the negative emotions that arise as a result of the trauma. Usually the term "psychic numbing" is used to refer to extreme cognitive and affective immoblization resulting from severe stress. However, the term might also be used to describe less extreme forms of mental and emotional repression.

Given the phenomena of psychic numbing, it is possible that distressful events increase empathic responsiveness, as found in Barnett and McCoy's (1989) study of the effects of distressful childhood experiences, unless and until the psyche becomes overwhelmed. At this point, the individual can respond in a number of ways. First, emotional pain and negative feelings may overwhelm the person, which would explain the aggressive behavior of the abused toddlers in the study conducted by Main and George (1985). Second, the human psyche may simply close itself off to the trauma and to its own emotional responses, which would result in a lack of empathic responsiveness or indifference. In some cases, this "closing off" can be so complete that the victim actually forgets the event and/or cannot remember the emotions that accompanied it. Third, the individual's reaction may result in a combination of negative emotions and some form of psychic numbing.

If this is what actually happens, empathic responsiveness would be affected differentially depending on the level of trauma experienced. Victims less severely traumatized by their abuse experiences would be more empathically responsive than those more severely traumatized or nonvictims. Conversely, victims more

severely traumatized by CSA would be less empathic than victims less traumatized or nonvictims. When the effects of the degree of recovery are added to this, the interaction between all of these variables becomes even more complex.

This relationship could be conceptualized in terms of a "trauma threshold". Up to a certain level, trauma may be expected to increase empathic responsiveness by broadening the individual's experiences, thus permitting greater identification with others. However, when the individual is traumatized to the extent that the "trauma threshold" is crossed, the psyche is overwhelmed with negative emotions resulting in decreased empathy.

The findings of this study add to existing knowledge about the long term effects of CSA and also challenge the idea that CSA inevitably results in negative consequences. However, in saying this, it is not being suggested that CSA is in any way a healthy experience, but that its effects on empathy may be ameliorated by the healing process, as well as other factors. In line with this reasoning, Finkelhor et. al. (1989) notes the fact that many CSA victims do not suffer the long-term effects experienced by other victims.

> This is not to argue, as some once did (Henderson, 1983; Ramey, 1979), that the impact of sexual abuse has been overstated. Rather, it is to point out that a history of sexual abuse is only a risk factor for developing an impairment and that the development of such a problem for any individual is far from inevitable. It is necessary to say this because many current victims of sexual abuse and their families are apt to acquire a distorted

> impression of what the consequences of abuse are.
> (Finkelhor et al., 1989, p. 395)

In addition, Finkelhor et al. also point out that the historical climate concerning CSA has changed significantly in the last 10 years. Public awareness and the reporting of abuse have increased as well as the availability of treatment services. "These changes may reduce the risk that sexual abuse will result in long-term impairments" (Finkelhor et al., 1989, p. 396).

Strengths, Limitations and Future Research

The present study has several strengths. The first is the use of a conservative and widely accepted definition of sexual abuse. A major problem in CSA research has been the use of definitions of sexual abuse that are too broad in range and the lack of agreement between researchers as to which definition is more accurate. Comparisons between studies have been difficult because early research failed to reach a consensus concerning definition. Later research has tended to define abuse as it is defined in this study.

A second strength is the use of a standardized measure of empathy with excellent psychometric properties (Davis, 1980 & 1983). In addition, this measure attempts to assess both cognitive and affective dimensions of empathic responsiveness. There is a great need in CSA research for the use of standardized means to confirm theoretical assumptions and clinical observations. This method and the IRI measure were chosen for this study for these reasons.

A third positive aspect of the present research is the participation of university students. This also has a negative aspect to it that is addressed later in this discussion. The positive side is that university students present a fairly homogenous group with respect to a number of important variables. This permits a greater accuracy in the investigation of relationships. The use of university students also permitted the participation of more people in the study than would have been possible through other means such as a clinic population. The method of group testing as opposed to individual interviews also permitted a larger sampling of individuals.

There are a number of limitations to this study. First, there are numerous methodological problems inherent in CSA research. Those relevant to this study include; the use of self-report measures, which is problematic for reasons mentioned earlier in this discussion and the use of retrospective reporting. This latter method suffers from participants' inability to remember events and from distortions due to development and affective states. Unreliability from these sources obscure relationships. However, these are some of the best methods available at this time to explore this area (Brender, Gagnon & Dubrow, 1988). In addition to these difficulties, "sequelae of CSA are moving targets; effects may be delayed or may assume different forms as a person matures" (Brender, Gagnon & Dubrow, 1988, p. 2). These problems must be considered when interpreting the results of studies on long-term effects of CSA.

Second, the use of university students may to some extent

compromise representativeness. Brender, Gagnon & Dubrow (1988) note that the result of using college students for this type of research is that samples are "biased in terms of higher intelligence, higher social class, greater personal motivation, mostly of white race, and from family backgrounds consisting predominantly of intact nuclear families" (p. 2).

Third, the Personal Experiences Questionnaire could be improved to permit a more indepth inquiry concerning the CSA experience and the symptomatology associated with CSA in adults. For example, participants could be asked to rate their feelings about the abuse at the time of its occurance and 5 years after the event, instead of giving a single overall rating. They could also be asked to rate the event(s) in terms of its importance. This would provide a more accurate estimate of trauma. In addition, CSA participants willing to be interviewed at a later time could be given the opportunity to indicate their interest by providing a place on the questionnaire for them to write their names and telephone numbers. Indepth personal interviews after initial participation may provide valuable information of a phenomenological nature that would help explain empirical data.

Fourth, the sample size did not permit certain types of analysis to be done. For example, it was possible to determine significant differences in scores between males and females, but within the group of seventeen males, only two reported having been sexually abused as children. Due to the small sample size, it was not possible

to determine the effect of CSA on empathy with males. Therefore, these results cannot be generalized to males.

Future research should use a larger sample that includes more males and improved measures of CSA trauma and recovery. Sources for participants other than university students should be explored. In addition, elements unique to each situation affect the degree to which a child is traumatized by sexual abuse. As mentioned in chapter two, some of the factors that have been found to affect the degree of trauma include the duration and frequency of the abuse; the type of sexual activity; the use of force or coercion; the victim's age; the age, gender and relationship of the offender; the active or passive participation of the victim; reactions of parents and others when abuse is disclosed; and the institutional response (Courtois, 1988). Exploring the relationship between these factors and empathic responsiveness as well as their relationship to general emotional development will increase understanding concerning the effects of CSA on the developing child.

In conclusion, the results of this study do not show any long-term effects of CSA on adult empathy as measured by the Interpersonal Reactivity Index. However, it cannot be presumed on the basis of these findings that there is no relationship between CSA and the development of empathy. It can be said that CSA does not inevitably lead to deficits in empathic responsiveness and given a high degree of recovery from the abuse, it appears unlikely that empathy is negatively affected or enhanced. The results are inconclusive

concerning the effects of the degree of recovery as well as the degree of trauma, but they provide a basis for further investigation. Future research should explore the possible effects of these variables and experiment with alternative ways of conceptualizing the relationship between CSA and empathy in order to address the complexity of this issue. The importance of empathy as it relates to effective interpersonal functioning cannot be overstressed particularly with regard to CSA victims who experience deficits in social skills. Increased knowledge in this area is imperative in order to enable professionals to assist victims of CSA on their way to recovery and will help society to prevent the future victimization of children.

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Appendix A

Interpersonal Reactivity Index

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter on the computer answer sheet next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBE ME WELL				DESCRIBES ME VERY WELL

FS 1. I daydream and fantasize, with some regularity, about things that might happen to me.

EC 2. I often have tender, concerned feelings for people less fortunate than me.

PT- 3. I sometimes find it difficult to see things from the "other guy's" point of view.

EC 4. Sometimes I don't feel very sorry for other people when they are having problems.

FS 5. I really get involved with the feelings of the characters in a novel.

PD 6. In emergency situations, I feel apprehensive and ill-at-ease.

FS- 7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

PT 8. I try to look at every body's side of a disagreement before I make a decision.

EC 9. When I see someone being taken advantage of, I feel kind of protective towards them.

PD 10. I sometimes feel helpless when I am in the middle of a very emotional situation.

PT 11. I sometimes try to understand my friends better by imagining how things look from their perspective.

FS- 12. Becoming extremely involved in a good book or movie is somewhat rare for me.

PD- 13. When I see someone get hurt, I tend to remain calm.

EC - 14. Other people's misfortunes do not usually disturb me a great deal.

PT- 15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

FS 16. After seeing a play or movie, I have felt as though I were one of the characters.

PD 17. Being in tense emotional situations scares me.

EC- 18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

PD- 19. I am usually pretty effective in dealing with emergencies.

EC 20. I am often quite touched by things that I see happen.

PT 21. I believe that there are two sides to every question and try to look at them both.

EC 22. I would describe myself as a pretty soft-hearted person.

FS 23. When I watch a good movie, I can very easily put myself in the place of a leading character.

PD 24. I tend to lose control during emergencies.

PT 25. When I'm upset at someone, I usually try to "put myself in his shoes" for awhile.

FS 26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

PD 27. When I see someone who badly needs help in an emergency, I go to pieces.

PT 28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

Appendix B

Personal Experiences Questionnaire

Please record your answers to these questions on the computer sheet beginning with item number 29.

29. Childhood sexual experiences can assume many forms. The types of experiences that are of interest in this study are those involving physical contact of a sexual nature, which includes any sexual activity from fondling to sexual intercourse. Before the age of 15, did anyone five or more years older than you initiate this type of sexual contact with you?

A. Yes
B. No
C. I think I have had this type of experience, but I'm not sure.
D. I don't remember.

30. Were you ever the victim of a violent sexual incident before the age of 17?

A. Yes
B. No
C. I think I have had this type of experience, but I'm not sure.
D. I don't remember.

31. If you answered "yes" to the first and/or the second question please choose ONE of the statements below that best describes how you have felt or now feel about your experience(s).

A. I found it to be a pleasant experience.

B. I have no feelings about it at all.

C. I found it to be a midly distressing experience(s).

D. I found it to be a very distressing experience(s).

E. I found it to be an extremely traumatic experience(s).

32. Before the age of 17, did you experience a significantly distressful event(s) (excluding the type of experience described in questions 29 & 30), such as, the death or loss of a close friend or family member, a life-threatening illness, the separation or divorce of parents, a serious accident, etc.?

A. Yes

B. No

C. I think I have had this type of experience, but I'm not sure.

D. I don't remember.

32. If you answered "yes" to question 31, which statement best describes your reaction to the significantly distressful event(s)?

A. I didn't find the event(s) upsetting because I was too young to understand what was happening (or) because it didn't seem important at the time (or) because of some other reason.

B. I found the event(s) to be mildly distressing.

C. I found the event(s) to be very distressing.

D. I found the event(s) to be traumatic.

E. I found the event(s) to be extremely traumatic.

33. This question is for those who have indicated by their answers to the previous questions that they have experienced either the type of sexual experiences specified in questions 29 & 30 and/or other significant distressful experiences as a child. If the experience(s) was negative for you, to what degree do you feel that you have recovered from the negative impact of this event? "Negative impact" is defined as the negative influence the event(s) may have had on various aspects of your life (physically, emotionally, mentally, and socially). Please choose ONE statement that best describes your feelings about this.

A. I have experienced little recovery and feel that the negative impact of the event(s) affects my life most of the time.

B. I have experienced some recovery, but frequently feel that the event(s) affects my life significantly in negative ways.

C. I have experienced some recovery and feel that the event(s) still is a negative influence in my life.

D. I have experienced significant recovery and feel that once in awhile, the event(s) has a negative effect on me.

E. I have recovered and this does not affect me in a negative way at all.

34. On the following scale, how would you rate yourself?

A	B	C	D	E
NOT VERY EMPATHIC				HIGHLY EMPATHIC

Appendix C

Debriefing

As I said earlier, this study is an exploration of the relationship between childhood sexual experiences and the development of empathy. The explanation of this study covers three areas. First, I want to explain the specific type of sexual experience we are studying and why it's significant. Second, I'll give you a definition of empathy and discuss factors thought to influence its developnent. Third, I'll present two studies which have investigated the effects of distressing childhood experiences on empathic responsiveness.

First of all, we're interested in a specific type of sexual experience in that (1) there had to have been some sort of physical contact (2) there had to have been a significant age difference and/or (3) the child was forced into sexual activity. If force was not used, the person initiating the contact had to be at least 5 years older than the child. The reason for the age difference is that we're interested in experiences that have an exploitive quality to them. An age difference of five years or more constitutes a significant difference in power between the older person who is initiating the sexual contact and the child. Because of the difference in power, sexual activity between an older person and a child can be viewed as an exploitive relationship. Therefore, the specific question being asked in this study is: What is the relationship between being sexually exploited as a child and the individual's empathic responsiveness as

an adult.

Second, those studying empathy in the past have generally viewed it in one of two ways; either as a cognitive role-taking ability that permits the empathic person to predict accurately the emotions of another or as "a vicarious emotional response to the perceived emotional experiences of others" (Mehrabian & Epstein, 1972). The first approach emphasizes the cognitive aspect of empathy and the second approach emphasizes the emotional aspect. More recently, researchers have attempted to integrate the two perspectives and that is what we've done in this study. The first questionnaire you completed assesses four aspects of empathy. Two are related to the cognitive elements involved in an empathic response and two are related to the emotional aspects.

Some of the environmental factors thought to influence the development of empathy are a secure early attachment between child and caretaker, parental affection, the availability of empathic models, parental socialization techniques that emphasize others feelings, and distressful childhood experiences.

This brings us to the third part of the discussion, which involves two studies that investigated the effects of distressful events during childhood on empathic responsiveness. The first study is by Mary Main & Carol George (1985) who investigated the effects of physical abuse on toddlers' empathic arousal. They found that a control group of nonabused toddlers who came from disadvantaged families reacted to the distress of other toddlers "with simple interest or with

concern, empathy, or sadness" (Main & George, 1985, p. 407). Main and George noted that these are the responses that are typical of toddlers in general. The abused children responded quite differently.

> Not one abused toddler showed concern in response to the distress of an agemate. Instead, the abused toddlers often reacted to an agemate's distress with disturbing behavior patterns not seen in the control toddlers, such as with physical attacks, fear, or anger. Three of the abused toddlers alternately attacked and attempted to comfort peers found in distress. (Main & George, 1985, p. 407)

These findings are consistent with present theory concerning the development of empathy. It is thought that when the child is in an environment that meets his/her emotional needs, he/she is able to be aware of and attend to the needs of others. Whereas, the child who's emotional needs are unmet remains unaware of others and their distress.

However, results from another study seem to contradict this idea. Mark Barnett and Sandra McCoy (1989) explored the relationship between distressful childhood experiences and empathy in college students. They found a positive correlation between the degree of reported distress experienced in childhood and measures of empathy. "Students who rated their distressful childhood experiences as highly distressing scored higher on both measures of empathy than did students who rated their experiences as relatively less distressing" (Barnett & McCoy, 1989, p.417). Interestingly enough, empathy was not related to the number of distressful experiences, but only to their

intensity.

The results from these two studies seems to be contradictory and I have not discovered any ready explanations to reconcile them. However, they have provided a basis for the present study in which you have participated. The literature is clear that sexual experiences that are exploitive in nature are often very distressing for both children and adults. What we don't know is the effects of these experiences on empathic responsiveness. It is most likely that an increase or decrease in empathy depends on many factors.

It is my belief that distressful or traumatic experiences of any kind impact the human psyche in a unique way. While they are often emotionally painful, they also create the potential for greater emotional depth. It can be likened to breaking a bone. As long as the bone is broken, the area is painful and movement is limited. However, if the conditions for healing are met, the bone will heal itself and become even stronger than it was originally. The break in the bone created the potential for a stronger bone. I am not advocating that we create distressing events for ourselves or others so that we can become more empathic, but only that we recognize that positive potential is inherent in negative experiences. Are there any questions about the study or anything that I have talked about?

If you have any other questions or concerns that you would like to discuss, please feel free to come and talk to me about it. You can see me after class or contact me at a later date in my office in the

Education Clinic. You can ask for me at the front desk and the secretary will direct you to my office. I have a handout here that has my office hours, the location of my office on it, and numbers at which I may be reached. Also if you are interested in research in this area and would like to talk more about it, please come and see me. (At this time, the researcher distributes handouts of where and how she may be contacted to interested participants.) I'd like to thank you all for your participation. It is my hope that research like this will help to prevent the sexual exploitation of children and to promote healing in adults who have been abused as children. Thank you again.

Appendix D

Table 1

Means, Standard Deviations and Significance of Differences Between CSA Victims and Nonvictims For Female Participants

Scale	M	SD	t-value	Prob.
Fantasy				
CSA Victims	17.28	6.38	-0.25	.80
Nonvictims	17.62	5.26		
Empathic Concern				
CSA Victims	21.07	4.71	-1.47	.15
Nonvictims	22.59	4.31		
Perspective Taking				
CSA Victims	19.10	4.25	0.16	.88
Nonvictims	18.95	4.38		
Personal Distress				
CSA Victims	10.38	5.67	-0.74	.46
Nonvictims	11.30	5.11		

n CSA victims = 29. n nonvictims = 61.

Table 2a

ANOVA Summary Results for Responses of Females on Fantasy Scale

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	12.59	2	6.29	.20	.82
Within	2787.90	87	32.04		
Total	2800.49	89			

n CSA = 29. n DCE = 28. n no CSA/DCE = 33.

Table 2b

ANOVA Summary Results for Responses of Females on Empathic Concern Scale

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	55.76	2	27.88	1.41	.25
Within	1724.34	87	19.82		
Total	1780.10	89			

n CSA = 29. n DCE = 28. n no CSA/DCE = 33.

Table 2c

ANOVA Summary Results for Responses of Females on Perspective Taking Scale

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	4.05	2	2.03	.11	.90
Within	1653.95	87	19.01		
Total	1658.00	89			

n CSA = 29. n DCE = 28. n no CSA/DCE = 33.

Table 2d

ANOVA Summary Results for Responses of Females on Personal Distress Scale

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	17.41	2	8.70	.20	.74
Within	2464.59	87	28.33		
Total	2482.00	89			

n CSA = 29. n DCE = 28. n no CSA/DCE = 33.

Table 3a

ANOVA Summary Results for Responses of Females on Fantasy Scale (n = 90)

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	30.98	3	10.33	.32	.81
Within	2769.51	86	32.20		
Total	2800.49	89			

n CSA = 10. n DCE = 28. n CSA/DCE = 19. n no CSA/DCE = 33

Table 3b

ANOVA Summary Results for Responses of Females on Empathic Concern Scale (n = 90)

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	45.72	3	15.24	.76	.52
Within	1734.38	86	20.17		
Total	1780.10	89			

n CSA = 10. n DCE = 28. n CSA/DCE = 19. n no CSA/DCE = 33

Table 3c

ANOVA Summary Results for Responses of Females on Perspective Taking Scale

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	6.68	3	2.22	.12	.95
Within	1651.32	86	19.20		
Total	1658.00	89			

n CSA = 10. n DCE = 28. n CSA/DCE = 19. n no CSA/DCE = 33

Table 3d

ANOVA Summary Results for Responses of Females on Personal Distress Scale

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	121.58	3	40.53	1.48	.23
Within	2360.42	86	27.45		
Total	2482.00	89			

n CSA = 10. n DCE = 28. n CSA/DCE = 19. n no CSA/DCE = 33

Tables 4a-4d

Note: Tables 4a-4d compare responses on the four empathy scales with respect to class membership. The following groups were included in the ANOVA's:

Educational Pscyhology 163 - Development n = 26

Educational Pscyhology 417 - Religious and Moral Development and Education n = 31

Educational Pscyhology 493 - Basic Issues in Contemporary Education n = 21

Educational Pscyhology 501 - Introduction to Methods of Educational Research n = 8

Educational Pscyhology 597 - Developmental Counselling Through Crisis n = 5

Christian Theology 431 - Christian Meaning of Sex and Marriage n = 18

Table 4a

ANOVA Summary Results for Responses on Fantasy Scale (n = 109)

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	348.62	5	69.72	2.25	.06
Within	3194.10	103	31.01		
Total	3542.72	108			

Table 4b

ANOVA Summary Results for Responses on Empathic Concern Scale (n = 109)

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	152.61	5	30.52	1.24	.30
Within	2531.63	103	24.58		
Total	2684.24	108			

Table 4c

ANOVA Summary Results for Responses of Females on Perspective Taking Scale (n = 109)

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	33.49	5	6.70	.28	.92
Within	2472.77	103	24.01		
Total	2506.26	108			

Table 4d

ANOVA Summary Results for Responses of Females on Personal Distress Scale (n = 109)

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	245.76	5	49.15	1.78	.12
Within	2838.66	103	27.56		
Total	3084.42	103			

Table 4d

ANOVA Summary Results for Responses of Females on Personal Distress Scale (n = 109)

Source of Variation	Sum of Squares	df	Mean Square	F	Prob.
Between	245.76	5	49.15	1.78	.12
Within	2838.66	103	27.56		
Total	3084.42	103			

Table 5

Multiple Regression Coefficients for Females on Four Empathy Scales

Scales	Multiple R	R^2	F	Prob.
Fantasy				
Equation 1	.14	.02	.49	.69
Equation 2	.16	.03	.40	.85
Empathic Concern				
Equation 1	.18	.03	.83	.48
Equation 2	.31	.09	1.52	.19
Perspective Taking				
Equation 1	.16	.03	.65	.59
Equation 2	.17	.03	.43	.83
Personal Distress				
Equation 1	.13	.02	.46	.71
Equation 2	.17	.03	.45	.81

Note: Equation 1 includes as variables: degree of CSA trauma, degree of DCE trauma and degree of recovery. Equation 2 includes all the variables of equation 1 and CSA/DCE group membership.